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October 17, 2016

VIA HAND DELIVERY

Ms. Ruby Potter
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Anne Arundel Medical Center
Docket No. 15-02-2360

Dear Commissioner Tanio:

Enclosed please find Anne Arundel Medical Center's Response to the October 5, 2016 memorandum of Commissioner Tanio.

Sincerely,

Jonathan Montgomery

Enclosures

cc: M. Natalie McSherry, Esquire (via email)
Christopher C. Jeffries, Esquire (via email)
Louis P. Malick, Esquire (via email)
John T. Brennan, Esquire (via email)
Joel I. Suldan, Esquire (via email)
Jinlene Chan, M.D., MPH (via email)
Steve R. Schuh, Executive, Anne Arundel County (via email)
Mr. Paul Parker (via email)
Mr. Kevin McDonald (via email)
Suellen Wideman, AAG (via email)
AAMC Internal Distribution (via email)

IN THE MATTER OF	*	
ANNE ARUNDEL MEDICAL CENTER	*	
Docket No. 15-02-2360	*	
* * * * * * *		BEFORE THE
IN THE MATTER OF UNIVERSITY	*	MARYLAND HEALTH CARE
OF MARYLAND BALTIMORE	*	COMMISSION
WASHINGTON MEDICAL CENTER	*	
Docket No. 15-02-2361	*	
* * * * * * * * * * * *		

ANNE ARUNDEL MEDICAL CENTER
REVISED TABLES & RESPONSE TO
BALTIMORE WASHINGTON MEDICAL CENTER OBJECTION

Anne Arundel Medical Center, Inc. ("**AAMC**"), by its undersigned counsel, hereby responds to the October 5, 2016 request of Commissioner Tanio (the "**Tanio Memo**") in regard to the input by the Health Services Cost Review Commission ("**HSCRC**"), namely, the HSCRC's August 24 memorandum to Commissioner Tanio (the "**HSCRC Memo**") in this Baltimore Upper Shore Cardiac Surgery Review (the "**Review**"). AAMC also hereby responds to the October 11, 2016 memorandum of Baltimore Washington Medical Center "(**BWMC**") objecting to the Tanio Memo.

I. Statements Regarding Revenue Requests

Enclosed please find statements pursuant to Questions 1 and 2 of the Tanio Memo. These statements are offered by Daniel B. Smith, Chief Financial Officer of Johns Hopkins Hospital, and Robert Reilly, Chief Financial Officer of Anne Arundel Medical Center. Both statements use the exact wording requested in the Tanio Memo.

II. The Revised Tables

Enclosed please find revised versions of AAMC financial schedules, namely revised Table G through Table K of AAMC's application (the "**Revised Tables**"), as requested by Commissioner Tanio.

Context helps in understanding the Revised Tables. AAMC, like other Maryland hospitals, operates under a global budget revenue system whereby the HSCRC sets the amount of revenue the hospital is allowed to earn annually, i.e. the aggregate revenue generated by each of AAMC's service lines. The HSCRC may adjust this budget in connection with particular service lines – for example, the HSCRC's market shift adjustment policy would permit AAMC's global budget revenue to increase by "50% of the cardiac surgery revenue" AAMC would generate.[1] The HSCRC may also adjust this budget on a global (non-service line) basis, for example through "the population adjustment, capacity from reduced avoidable utilization"[2] and the HSCRC's annual update to each hospital's budget to reflect inflation and the like. In that regard, the HSCRC Memo indicates that the HSCRC would also allow "reallocation of overhead already funded"[3] by AAMC's budget to AAMC's proposed cardiac surgery program "to cover the difference between marginal cost and fully allocated that includes existing overhead".[4]

AAMC's original financial projections for the cardiac surgery program combined both of the these revenue sources without distinguishing one from another, namely (1) revenue generated directly by the proposed cardiac surgery program, and (2) revenue allocated to the cardiac surgery program through use of "resources provided in the system" such as the demographic

[1] HSCRC Memo at p. 1.

[2] HSCRC Memo at p. 1.

[3] HSCRC Memo at p. 1

[4] HSCRC Memo at p. 2.

adjustment, as noted in the HSCRC Memo. In fact, in its July 27, 2015 comment on BWMC's application, AAMC acknowledged "the new 50% variable cost factor for market shift adjustments"[5], but noted that the HSCRC would permit AAMC to allocate to the program revenue through the other resources provided in the system for new projects, such as "the annual update process for individual hospital budgets."[6] AAMC acknowledges that its original financial presentation did not clearly distinguish between these two sources of program revenue, but the Revised Tables do just that.

Therefore, the Revised Tables now clearly distinguish between revenue allocated to the project pursuant to (1) the HSCRC's market shift policy, and (2) allocation of general budget increases received by AAMC. In other words, the Revised Tables do not add or subtract any revenue. The Revised Tables simply split out the previously described revenue into these two categories, as described in the HSCRC Memo and as requested by Commissioner Tanio. The Revised Tables now also reflect that this allocation of these general budget increases would not increase AAMC's entire facility revenue.

Just as the tables included in AAMC's original application, the Revised Tables continue to demonstrate that AAMC can build a financially feasible cardiac surgery program, a program which will deliver substantial savings to cardiac surgery patients and the health care system as a whole.

III. BWMC Objections

Commissioner Tanio should reject the objections to the Revised Tables presented in BWMC's memo for the following reasons.

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[5] AAMC July 27, 2015 Comment on BWMC Application at p.15, n. 42.

[6] AAMC July 27, 2015 Comment on BWMC Application at p.15, n. 42.

First, the Revised Tables do not present material changes to the financial projections presented in AAMC's original application. The "bottom line" numbers of the cardiac surgery program have not changed. Rather, the Revised Tables simply clarify the portion of AAMC's projected revenue derived from the market shift policy as opposed to other allocations of revenue to the program permitted by the HSCRC. Moreover, early in this process, AAMC acknowledged "the new 50% variable cost factor for market shift adjustments"[7] for cardiac program revenue while at the same time noting that the HSCRC has the flexibility to provide targeted funding to AAMC's cardiac surgery program through the general update process for individual hospital budgets.[8] This is the same two-track revenue allocation process described in the HSCRC Memo. Therefore, the Revised Tables are not an "improper modification" of AAMC's application. Nor has AAMC "failed to document financial feasibility" as claimed by BWMC. Rather, the HSCRC has concluded that AAMC's cardiac surgery program would be financially feasible given the sources of revenue available for AAMC to allocate to the project[9], and the Revised Tables now reflect the financial projection methodology articulated in the HSCRC Memo.

Second, even if the Revised Tables did constitute a modification to AAMC's application (which they do not), such modifications are entirely permissible pursuant to a project status conference, which may be held at any time to identify "aspects of a proposed project that appear to be inconsistent with applicable standards and review criteria" and request "additional filings" in response[10], as acknowledged by BWMC.[11]

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[7] AAMC July 27, 2015 Comment on BWMC Application at p.15, n. 42.

[8] AAMC August 25, 2015 Response to Interested Party Comments

[9] HSCRC Memo at pp. 2-3.

[10] COMAR 10.24.01.09(A)(2); *see also* COMAR 10.24.01.08(E)(2).

[11] BWMC memorandum at p. 2 (citing COMAR 10.24.01.08(E)(2)).

In that regard, the certificate of need regulations do not specify the form in which a project status conference may be held. Arguably, the Tanio Memo constitutes a project status conference. This Review has been conducted by written filings exclusively to this point, without resort to hearings or oral argument. AAMC perceives no reason why this pattern should not continue or how an oral presentation of the Tanio Memo would help this Review. If Commissioner Tanio chooses to deem the Tanio Memo a project status conference, AAMC would not object to BWMC having the requisite seven days to respond. Otherwise, AAMC would be happy to submit the Revised Tables pursuant to a live project status conference if that is preferred.

BWMC's argument that a project status conference would be futile is absurd. The project status conference process exists precisely to give the Commission the benefit of each applicant's best case for obtaining a certificate of need. Here, the proposed creation of a new cardiac surgery program in the State of Maryland implicates important issues of public health and health care delivery, especially for the people of Anne Arundel County in need of these services. Although the Commission must certainly observe the procedural rules of the certificate of need process, this Review should be decided on substance, not BWMC's "gotcha" argument.

Moreover, the entire point of the project status conference process is to give applicants a chance to respond to concerns raised by the **reviewer or staff** about a project's consistency with review standards, not concerns raised in "written comments"[12] by other applicants (contra BWMC).[13] Further, as discussed above, the Revised Tables confirm that AAMC's proposed

[12] BWMC memorandum at p. 2.

[13] For example, in the Prince George's Regional Medical Center review, interested parties commented that the proposed replacement hospital project was too large, too costly, and too indifferent to the need for investment in Prince George's County's ambulatory care system. However, it was not until Commissioner Moffitt held a project review conference in May 2016 that the applicants modified the proposed project to address these concerns.

cardiac surgery program would be financially feasible.[14] This nullifies the key premise of BWMC's futility argument, namely that no revised financial projection of AAMC could demonstrate feasibility under the HSCRC's market shift policy.

IV. Conclusion

For all the foregoing reasons, AAMC is pleased to provide its and Johns Hopkins' commitments (enclosed) and the Revised Tables (enclosed), and requests that the Commission accept these submissions while rejecting BWMC's objections thereto.

Respectfully submitted,

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Attorneys for Anne Arundel Medical Center

Date: October 17, 2016

[14] Indeed, whether or how much either applicant's global budget increases in connection with a proposed new hospital service line does not determine the financial feasibility of that service line, only the revenue of the hospital as a whole. That is, the GBR system does not prevent the new service line from earning revenue and thus being viable as a service line. Rather, the GBR system requires the hospital decrease its charges for **all** service lines to remain within the global budget cap while absorbing the additional revenue associated with the new service line.

Revised Tables

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2017**	**FY 2018**	**FY 2019**				
1. REVENUE										
a. Inpatient Services	$ 294,098,900	$ 292,960,600	$ 297,654,040	$ 302,181,942	$ 303,973,116	$ 304,885,277				
b. Outpatient Services	$ 239,409,200	$ 253,443,600	$ 254,587,463	$ 253,953,060	$ 253,956,509	$ 253,960,054				
Gross Patient Service Revenues	***$ 533,508,100***	***$ 546,404,200***	***$ 552,241,503***	***$ 556,135,002***	***$ 557,929,625***	***$ 558,845,331***	$ -	$ -	$ -	$ -
c. Allowance For Bad Debt	$ 19,750,800	$ 22,623,500	$ 26,145,184	$ 26,303,664	$ 26,366,353	$ 26,398,282				
d. Contractual Allowance	$ 53,366,400	$ 60,024,200	$ 55,603,875	$ 56,115,030	$ 56,317,572	$ 56,420,930				
e. Charity Care	$ 8,912,500	$ 5,721,800	$ 2,774,084	$ 2,796,724	$ 2,805,680	$ 2,810,240				
Net Patient Services Revenue	***$ 451,478,400***	***$ 458,034,700***	***$ 467,718,360***	***$ 470,919,584***	***$ 472,440,020***	***$ 473,215,880***	$ -	$ -	$ -	$ -
f. Other Operating Revenues	$ 26,036,200	$ 25,995,000	$ 30,197,196	$ 30,157,196	$ 30,157,196	$ 30,157,196				
NET OPERATING REVENUE	***$ 477,514,600***	***$ 484,029,700***	***$ 497,915,556***	***$ 501,076,780***	***$ 502,597,216***	***$ 503,373,076***	$ -	$ -	$ -	$ -
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 222,592,080	$ 221,047,100	$ 228,259,601	$ 235,991,612	$ 237,393,158	$ 239,600,264				
b. Contractual Services	$ 2,851,345	$ 716,000	$ 245,942	$ 248,167	$ 248,664	$ 249,623				
c. Interest on Current Debt	$ 15,972,794	$ 15,182,000	$ 14,096,925	$ 13,555,176	$ 13,301,038	$ 13,041,376				
d. Interest on Project Debt										
e. Current Depreciation	$27,952,182	$29,211,500	$29,396,532	$ 29,452,079	$ 28,642,928	$ 28,502,319				
f. Project Depreciation				$ 315,319	$ 315,319	$ 315,319				
g. Current Amortization	$ 418,365	$ 392,500	$ 390,407	$ 307,008	$ 307,008	$ 307,008				
h. Project Amortization										
i. Supplies	$ 115,094,050	$ 117,119,100	$ 115,931,587	$ 107,621,203	$ 105,810,629	$ 102,989,400				
j. Other Expenses (Specify/add rows if needed)	$ 91,519,202	$ 88,249,400	$ 89,396,313	$ 84,703,874	$ 82,984,745	$ 80,555,423				
TOTAL OPERATING EXPENSES	***$ 476,400,018***	***$ 471,917,600***	***$ 477,717,307***	***$ 472,194,438***	***$ 469,003,487***	***$ 465,560,733***	$ -	$ -	$ -	$ -
3. INCOME										
a. Income From Operation	**$ 1,114,582**	**$ 12,112,100**	**$ 20,198,249**	**$ 28,882,341**	**$ 33,593,728**	**$ 37,812,343**	$ -	$ -	$ -	$ -
b. Non-Operating Income	$ 44,226,600	$ 27,091,100	$ (31,684,793)	$ 16,919,694	$ 20,690,944	$ 24,933,376				
SUBTOTAL	***$ 45,341,182***	***$ 39,203,200***	***$ (11,486,543)***	***$ 45,802,036***	***$ 54,284,672***	***$ 62,745,719***	$ -	$ -	$ -	$ -
c. Income Taxes										
NET INCOME (LOSS)	***$ 45,341,182***	***$ 39,203,200***	***$ (11,486,543)***	***$ 45,802,036***	***$ 54,284,672***	***$ 62,745,719***	$ -	$ -	$ -	$ -

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	FY 2013	FY 2014	FY 2015	FY 2017	FY 2018	FY 2019				
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	40.2%	40.3%	39.6%	39.6%	39.6%	39.6%				
2) Medicaid	6.6%	9.3%	10.8%	10.8%	10.8%	10.8%				
3) Blue Cross	21.2%	19.3%	17.9%	17.9%	17.9%	17.9%				
4) Commercial Insurance	21.4%	27.0%	28.1%	28.1%	28.1%	28.1%				
5) Self-pay	3.1%	1.3%	0.9%	0.9%	0.9%	0.9%				
6) Other	7.5%	2.9%	2.7%	2.7%	2.7%	2.7%				
TOTAL	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
b. Percent of Equivalent Inpatient Days										
1) Medicare	40.2%	40.3%	39.6%	39.6%	39.6%	39.6%				
2) Medicaid	6.6%	9.3%	10.8%	10.8%	10.8%	10.8%				
3) Blue Cross	21.2%	19.3%	17.9%	17.9%	17.9%	17.9%				
4) Commercial Insurance	21.4%	27.0%	28.1%	28.1%	28.1%	28.1%				
5) Self-pay	3.1%	1.3%	0.9%	0.9%	0.9%	0.9%				
6) Other	7.5%	2.9%	2.7%	2.7%	2.7%	2.7%				
TOTAL	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2017**	**FY 2018**	**FY 2019**				
1. REVENUE										
a. Inpatient Services	$ 294,098,900	$ 292,960,600	$ 297,654,040	$ 318,341,878	$ 328,648,242	$ 338,282,901				
b. Outpatient Services	$ 239,409,200	$ 253,443,600	$ 254,587,463	$ 266,809,830	$ 273,484,577	$ 280,326,773				
Gross Patient Service Revenues	***$ 533,508,100***	***$ 546,404,200***	***$ 552,241,503***	***$ 585,151,708***	***$ 602,132,819***	***$ 618,609,674***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 19,750,800	$ 22,623,500	$ 26,145,184	$ 27,635,155	$ 28,397,122	$ 29,146,625				
d. Contractual Allowance	$ 53,366,400	$ 60,024,200	$ 55,603,875	$ 57,727,320	$ 58,792,706	$ 59,784,713				
e. Charity Care	$ 8,912,500	$ 5,721,800	$ 2,774,084	$ 2,938,290	$ 3,021,902	$ 3,103,103				
Net Patient Services Revenue	***$ 451,478,400***	***$ 458,034,700***	***$ 467,718,360***	***$ 496,850,944***	***$ 511,921,089***	***$ 526,575,234***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)	$ 26,036,200	$ 25,995,000	$ 30,197,196	$ 31,203,328	$ 31,711,634	$ 32,230,107				
NET OPERATING REVENUE	***$ 477,514,600***	***$ 484,029,700***	***$ 497,915,556***	***$ 528,054,271***	***$ 543,632,723***	***$ 558,805,340***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 222,592,080	$ 221,047,100	$ 228,259,601	$ 248,737,129	$ 256,786,669	$ 265,897,175				
b. Contractual Services	$ 2,851,345	$ 716,000	245,942	253,155	256,198	259,759				
c. Interest on Current Debt	$ 15,972,794	$ 15,182,000	14,096,925	13,555,176	13,301,038	13,041,376				
d. Interest on Project Debt	$ -	$ -								
e. Current Depreciation	$ 27,952,182	$ 29,211,500	29,396,532	29,452,079	28,642,928	28,502,319				
f. Project Depreciation	$ -	$ -		315,319	315,319	315,319				
g. Current Amortization	$ 418,365	$ 392,500	390,407	307,008	307,008	307,008				
h. Project Amortization	$ -	$ -								
i. Supplies	$ 115,094,050	$ 117,119,100	115,931,587	118,510,331	122,853,218	126,853,721				
j. Other Expenses (Specify/add rows if needed)	$ 91,519,202	$ 88,249,400	89,396,313	92,087,575	94,325,880	96,044,317				
TOTAL OPERATING EXPENSES	***$ 476,400,018***	***$ 471,917,600***	***$ 477,717,307***	***$ 503,217,771***	***$ 516,788,258***	***$ 531,220,993***	***$ -***	***$ -***	***$ -***	***$ -***
3. INCOME										
a. Income From Operation	**$ 1,114,582**	**$ 12,112,100**	**$ 20,198,249**	**$ 24,836,500**	**$ 26,844,465**	**$ 27,584,347**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income	$ 44,226,600	$ 27,091,100	$ (31,684,793)	$ 16,716,597	$ 20,162,033	$ 23,870,184				
SUBTOTAL	***$ 45,341,182***	***$ 39,203,200***	***$ (11,486,543)***	***$ 41,553,097***	***$ 47,006,498***	***$ 51,454,531***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes										
NET INCOME (LOSS)	***$ 45,341,182***	***$ 39,203,200***	***$ (11,486,543)***	***$ 41,553,097***	***$ 47,006,498***	***$ 51,454,531***	***$ -***	***$ -***	***$ -***	***$ -***

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2017**	**FY 2018**	**FY 2019**				
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	40.2%	40.3%	39.6%	39.6%	39.6%	39.6%				
2) Medicaid	6.6%	9.3%	10.8%	10.8%	10.8%	10.8%				
3) Blue Cross	21.2%	19.3%	17.9%	17.9%	17.9%	17.9%				
4) Commercial Insurance	21.4%	27.0%	28.1%	28.1%	28.1%	28.1%				
5) Self-pay	3.1%	1.3%	0.9%	0.9%	0.9%	0.9%				
6) Other	7.5%	2.9%	2.7%	2.7%	2.7%	2.7%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days										
Total MSGA										
1) Medicare	40.2%	40.3%	39.6%	39.6%	39.6%	39.6%				
2) Medicaid	6.6%	9.3%	10.8%	10.8%	10.8%	10.8%				
3) Blue Cross	21.2%	19.3%	17.9%	17.9%	17.9%	17.9%				
4) Commercial Insurance	21.4%	27.0%	28.1%	28.1%	28.1%	28.1%				
5) Self-pay	3.1%	1.3%	0.9%	0.9%	0.9%	0.9%				
6) Other	7.5%	2.9%	2.7%	2.7%	2.7%	2.7%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
1. REVENUE							
a. Inpatient Services	$ 3,893,208	$ 5,687,956	$ 6,603,444				
b. Reallocated revenues - See Note 1	$ 2,725,245	$ 3,981,569	$ 4,622,411				
Gross Patient Service Revenues	***$ 6,618,453***	***$ 9,669,525***	***$ 11,225,855***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 269,393	$ 375,975	$ 430,236				
d. Contractual Allowance	$ 869,754	$ 1,213,863	$ 1,389,047				
e. Charity Care	$ 38,485	$ 53,711	$ 61,462				
Net Patient Services Revenue	***$ 5,440,821***	***$ 8,025,977***	***$ 9,345,110***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues							
NET OPERATING REVENUE	***$ 5,440,821***	***$ 8,025,977***	***$ 9,345,110***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 3,042,302	$ 3,397,763	$ 3,582,372				
b. Contractual Services							
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation	$ 315,319	$ 315,319	$ 315,319				
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 1,687,904	$ 2,466,749	$ 2,873,906				
j. Other Expenses (Specify)	$ 1,899,518	$ 1,830,391	$ 1,702,183				
TOTAL OPERATING EXPENSES	***$ 6,945,043***	***$ 8,010,222***	***$ 8,473,780***	***$ -***	***$ -***	***$ -***	***$ -***
3. INCOME							
a. Income From Operation	**$ (1,504,221)**	**$ 15,755**	**$ 871,330**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income							
SUBTOTAL	***$ (1,504,221)***	***$ 15,755***	***$ 871,330***	***$ -***	***$ -***	***$ -***	***$ -***

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
c. Income Taxes							
NET INCOME (LOSS)	***$ (1,504,221)***	***$ 15,755***	***$ 871,330***	***$ -***	***$ -***	***$ -***	***$ -***

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	50.2%	51.9%	52.9%				
2) Medicaid	6.8%	6.8%	6.8%				
3) Blue Cross	9.3%	9.3%	9.3%				
4) Commercial Insurance	30.6%	28.9%	27.9%				
5) Self-pay	2.5%	2.5%	2.5%				
6) Other	0.6%	0.6%	0.6%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare	50.2%	51.9%	52.9%				
2) Medicaid	7.3%	7.3%	7.3%				
3) Blue Cross	9.0%	9.0%	9.0%				
4) Commercial Insurance	30.0%	28.4%	27.4%				
5) Self-pay	2.9%	2.9%	2.9%				
6) Other	0.6%	0.6%	0.6%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

Note 1: Per the HSCRC, revenue can be reallocated from other revenue sources (HSCRC Memorandum of 8/24/16 to MHCC)

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
1. REVENUE							
a. Inpatient Services	$ 4,087,868	$ 6,114,553	$ 7,263,789				
b. Reallocated revenues - See Note 1	$ 2,861,508	$ 4,280,187	$ 5,084,652				
Gross Patient Service Revenues	***$ 6,949,375***	***$ 10,394,740***	***$ 12,348,441***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 282,863	$ 404,173	$ 473,260				
d. Contractual Allowance	$ 913,241	$ 1,304,902	$ 1,527,952				
e. Charity Care	$ 40,409	$ 57,739	$ 67,608				
Net Patient Services Revenue	***$ 5,712,862***	***$ 8,627,925***	***$ 10,279,621***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows of needed)							
NET OPERATING REVENUE	***$ 5,712,862***	***$ 8,627,925***	***$ 10,279,621***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 3,163,994	$ 3,601,628	$ 3,868,962				
b. Contractual Services							
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation	$ 315,319	$ 315,319	$ 315,319				
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 1,228,148	$ 2,095,246	$ 2,585,649				
j. Other Expenses (Specify/add rows of needed)	$ 2,442,273	$ 2,372,968	$ 2,251,816				
TOTAL OPERATING EXPENSES	***$ 7,149,734***	***$ 8,385,161***	***$ 9,021,745***	***$ -***	***$ -***	***$ -***	***$ -***
3. INCOME							
a. Income From Operation	**$ (1,436,872)**	**$ 242,764**	**$ 1,257,876**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income							
SUBTOTAL	***$ (1,436,872)***	***$ 242,764***	***$ 1,257,876***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes							

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	FY 2017	FY 2018	FY 2019				
NET INCOME (LOSS)	*$ (1,436,872)*	*$ 242,764*	*$ 1,257,876*	*$ -*	*$ -*	*$ -*	*$ -*

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**				
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	50.2%	51.9%	52.9%				
2) Medicaid	6.8%	6.8%	6.8%				
3) Blue Cross	9.3%	9.3%	9.3%				
4) Commercial Insurance	30.6%	28.9%	27.9%				
5) Self-pay	2.5%	2.5%	2.5%				
6) Other	0.6%	0.6%	0.6%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
1) Medicare	50.2%	51.9%	52.9%				
2) Medicaid	7.3%	7.3%	7.3%				
3) Blue Cross	9.0%	9.0%	9.0%				
4) Commercial Insurance	30.0%	28.4%	27.4%				
5) Self-pay	2.9%	2.9%	2.9%				
6) Other	0.6%	0.6%	0.6%				
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

Note 1: Per the HSCRC, revenue can be reallocated from other revenue sources (HSCRC Memorandum of 8/24/16 to MHCC)

Johns Hopkins Hospital

Statement

Daniel B. Smith
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JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
HEALTH SYSTEM

Craig P. Tanio, M.D.
Chair, Maryland Health Care Commission
Reviewer, Baltimore Upper Shore Cardiac Surgery Review
4160 Patterson Avenue
Baltimore, MD 21215

October 14, 2016

Re: Baltimore Upper Shore Cardiac Surgery Review

Dear Dr. Tanio:

This letter is in response to correspondence to the applicants in the above-referenced matter, dated October 5, 2016. Question 2 is specifically addressed to The Johns Hopkins Hospital ("JHH") as the "collaborating hospital" in the Anne Arundel Medical Center application.

In response to Question 2, JHH commits that, if the Anne Arundel Medical Center is issued a CON to establish a new cardiac surgery program, JHH will not approach the HSCRC in the future to request an increase in global budgeted revenue that has as any part of its basis, the lost revenue generated by cardiac surgery services that have shifted to Anne Arundel Medical Center, our partner applicant hospital.

Please let us know if there is any additional information we can provide that would be helpful to your review.

Sincerely,

Daniel B. Smith

Anne Arundel Medical Center

Statement

Anne Arundel Medical Center

2001 Medical Parkway
Annapolis, Md. 21401
443-481-1000
TDD: 443-481-1235
askAAMC.org

October 17, 2016

VIA EMAIL & FEDERAL EXPRESS

Craig Tanio, M.D.
Chair/Reviewer
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Commissioner Tanio,

AAMC commits that, if AAMC is issued a CON to establish a new cardiac surgery program, it will not approach the HSCRC in the future to request an increase in global budgeted revenue that has, as any part of its basis, the objective of obtaining additional revenue from the provision of cardiac surgery services.

That is, per the HSCRC's memo, AAMC will not "seek a rate increase in a separate action" outside this certificate of need process, nor will it "approach the HSCRC to request an increase in [its] allowed GBR revenue if the GBR methodology does not provide sufficient revenue."

AAMC understands that this commitment does not prevent it from (per the HSCRC's Memo): (a) receiving global budget revenue increases for cardiac surgery "consistent with the HSCRC market shift policy" yielding an effective 50% variable cost factor for incremental cardiac surgery volume for both volume shifts among Maryland hospitals as well as in-migration of Maryland residents previously treated in the District of Columbia; (b) allocating to the cardiac surgery program "increases in revenue under the new payment model using the resources that are provided in the system"; or (c) similarly allocating revenue to the cardiac surgery program in connection with future revisions to the HSCRC's GBR policy or rate methodologies.

Sincerely,

Bob Reilly
Chief Financial Officer

Attestation

ANNE ARUNDEL MEDICAL CENTER

CARDIAC SURGERY PROGRAM CERTIFICATE OF NEED APPLICATION

RESPONSE TO TANIO MEMORANDUM

Attestation by Robert Reilly

Affirmation: I solemnly affirm under the penalties of perjury that the contents of this response are true to the best of my knowledge, information and belief.

October 17, 2016
Date

Signature

CFO, Anne Arundel Medical Center
Position/Title